Care Fusion INFUSION CENTERS

**AIC Osteoporosis**

**Fax: 855-733-9898**
**Phone: 877-460-3905**

## Patient Information

Patient Name: _____ DOB: _____ Height: _____ Weight: _____ Patient Contact #: _____

## Medical Assessment

Diagnosis:

- ❑ M80.0 __ Age related Osteoporosis with current fracture
- ❑ M81.0 Age related Osteoporosis without current fracture
- ❑ C61 Malignant Neoplasm of the Prostate
- ❑ C50. __ Breast Cancer
- ❑ Other: _____

Failed Medications: _____

Has the patient tried and failed oral bisphosphonates? If so, which ones and when? _____

Dexa Scan T Score: _____ Type: _____ Date: _____

Fracture History: Site _____ Date: _____

****Please include a demographics page, front and back of an insurance card, any clinical notes with supporting diagnosis, lab-work, tests, and any other supporting documentation including past tried and / or failed therapies associated with diagnosis****

## Pre-Medication Orders:

- ❑ APAP □ 325mg □ 500mg □ 650mg - PO 30 minutes before infusion.
- ❑ Diphenhydramine □ 25mg □ 50mg – PO 30 minutes before infusion OR □ 25mg IVP □ 50mg IVP
- ❑ Alternate Oral Antihistamines: □ Cetirizine 10mg □ Loratadine 10mg □ Fexofenadine 60mg or □180mg
- ❑ Methylprednisolone □ 40mg IVP □ 125mg IVP or other ____ mg IVP
- ❑ Famotidine □ 20mg PO □ 40mg PO □ 20mg IVP □ 40mg IVP
- ❑ Ondansetron □ 4 mg IVP □ 4 mg PO

**Labwork**: _____ To be Drawn by: □ Infusion Clinic □ Referring Provider

**Allergies:** _____

## Medication

**Evenity (romosozumab-aqqg)**

Dosage / Frequency:

- ❑ Evenity 210mg SQ monthly for 12 months.
- ❑ **Maintenance Refills**: ___

**Ibandronate Sodium (generic Boniva)**

Dosage / Frequency:

- ❑ Ibandronate 3 mg IVevery 3 months.
- ❑ **Maintenance Refills**: ___

## Physician Prescription Orders

Address: _____ Phone: _____Fax: _____

Clinic Contact: _____ Physician Name: _____

***NPI #_____Physician Signature:*** _____***Date:*** _____